VIRGINIA DEPARTMENT OF HEALTH
ADAP MEDICATION EXCEPTION FORM

PATIENT NAME (Last, First, MI):			
D.O.B. (mm/dd/yy):	**AGE:**	**SEX:** ☐ **MALE**	☐ **FEMALE**
ADDRESS	**CITY**	**STATE**	**ZIP**
RACE/ETHNICITY: ☐ White (non-Hispanic) ☐ African American/Black (non-Hispanic) ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian, Aleutian, Eskimo ☐ Unknown			
HEALTH DEPARTMENT PHONE #		**HEALTH DEPARTMENT FAX #**	
LOCAL HEALTH DEPARTMENT ADAP CONTACT PERSON:			
PRESCRIBING PHYSICIAN NAME:			
PHYSICIAN PHONE #:			
FORM COMPLETED BY (Name):			
TITLE:		**DATE (mm/dd/yy):**	
MEDICATION REQUESTED:			
REASON FOR EXCEPTION: _____			

Specify other anti-retroviral medications patient is currently on (fuzeon should be added to current therapy)

NAME OF MEDICATION	DOSE	DATE STARTED	DATE DISCONTINUED

LABORATORY HISTORY
Please start with the most current results (give at least two (2) results if available)

VIRAL LOAD RESULTS	DATE	CD4 COUNT RESULTS	DATE

VDH USE ONLY

☐ **Request Approved** ☐ **Request Denied**

Rational:_____

_____

Signature:_____ **Date:**_____

Fax to CENTRAL ADAP office, ADAP Coordinator at (804) 864-8050

Revised 10/01/2004

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment